STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	C 04/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete, accurately documented medical record for one resident (#2) of six sampled residents. The findings included: Resident #2 was admitted to the facility on February 25, 2010, with diagnoses including Senile and Presenile Organic Psychotic Condition, Chronic Airway Obstruction, and Diastolic Heart Failure. Medical record review of the Minimum Data Set dated March 3, 2010, revealed the resident needed assistance with decision-making in new situations only and displayed a pattern of mood problems. Continued review revealed the resident needed extensive assistance with mobility and hygiene, and had daily moderate pain. Medical record review of a physician's order dated February 26, 2010,	F 514	F 514 What corrective action that will be accomplished that facility failed to maintain a complete, accurrately documented medical record. The nurse found to have failed to document assessment accurrately was written up and inserviced on proper assessing and documentation of resident assessment. How the facility will identify other residents that could have the potential to be affected by the practice that facility failed to document accurrately. All residents have the potential to be affected. All nurses have been inserviced on proper assessing and documentation of that assessment in resident's medical record, also inserviced on circling of meds without accurrate documentation of why med not given. What measures will be put into place to ensure that deficient practice does not recurr. The L.P.N. chart auditor will check all residents records bi-annually and check MARS monthly for circled medications without acurrate documentation as to why med not given. see attached inservices and write up for nurse. 05-03-10 How the corrective actions will be monitored to ensure the deficient practice does not recur. Records will be checked bi-annually and monthly with MARS. Will monitor and address in QI bi-annually x's 2, then yearly. QI team consists of Adminstrators, DON, ADON, Pharmacist, Medical Director, MDS Coordinators, Social Workers, Dietary Manager, Activity Director, Rehab Manager, Housekeeping and Maintenace supervisors. 05-03-10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 5-3-2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 514	Continued From page 1	F 514		

revealed, "Ambien (sedative) 10 mg (milligram) po hs (by mouth at bedtime) Hold for sedation..." Medical record review of a physician's order dated March 1, 2010, revealed, "...Percocet (narcotic pain medication) 10/325 q 6 h routine (every six hours)..."

Medical record review of a nurse's note dated April 2, 2010, at 10:10 p.m., revealed, "This nurse telephoned per resident's son - states 'My mother called me said that (resident) had a stroke.' cont (continued) to ask questions about if his mother could walk go to the bathroom etc -." Medical record review of the next nurse's note entry dated April 3, 2010, at 5:00 a.m., revealed, "CNA (certified nursing assistant) called nurse into room...coughing slurred speech...call into on-call Dr (doctor)..." Medical record review of a nurse's note dated April 3, 2010, at 5:15 a.m., revealed, "Dr...return call...pt sent out..." Medical record review revealed the resident had not returned to the facility.

Medical record review of the Medication Administration Record (MAR) dated April 2, 2010, revealed the 12:00 p.m. and 6:00 p.m. doses of Percocet had been initialed and circled (indicates medication not given). Continued review of the MAR dated April 2, 2010, revealed the 8:00 p.m. dose of Ambien had been initialed and circled. Review of the Nurses Medication Notes dated April 2, 2010, revealed no documentation regarding a reason the medications had not been administered.

Telephone interview with registered nurse (RN #1) (responsible for the nurse's note dated April 2, 2010, at 10:10 p.m. and the circled initials) on April 20, 2010, at 1:03 p.m., revealed the RN

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F 514	Continued From page 2 assessed the resident following the phone conversation with the resident's son, and the resident was alert, oriented, and requested an as needed pain medication. Continued interview revealed the nurse advised the resident a scheduled dose could be given within the hour, and the as needed pain medication was not administered. Continued interview revealed the resident requested an as needed anti-anxiety medication, and the nurse administered the anti-anxiety medication. Continued interview revealed the sedative was not administered on April 2, 1010, at 8:00 p.m., due to sedation. Continued interview revealed RN #1 had failed to document the explanations for the medications having not been administered and the nursing assessment of the resident on April 2, 2010, after the nurse's note at 10:10 p.m. Continued interview confirmed the facility had failed to accurately and completely maintain Resident #2's medical record. C/O: #25540	F 514		